ADVANCED UROLOGY of SOUTH FLORIDA

a division of UGF

Lawrence M. Yore, MD, FACS
Edward Scheckowitz, MD, FACS
Emanuel Gottenger, MD, FACS

5350 W. Atlantic Ave., Ste. 102, Delray Beach

DATE:

NAME	SEX: M ____ F ____	DATE OF BIRTH	AGE	SOCIAL SECURITY NO.
STREET ADDRESS ☐ PERMANENT ☐ TEMPORARY APT #	CITY AND STATE		ZIP CODE	HOME PHONE NO.
PATIENT'S EMPLOYER	OCCUPATION (CURRENT/FORMER)	HOW LONG EMPLOYED?		MOBILE PHONE NO.
EMPLOYER'S STREET ADDRESS	CITY AND STATE			ZIP CODE
SPOUSE'S / PARTNER'S NAME	NUMBER OF CHILDREN AND AGES			MARITAL STATUS S M DP W D
SPOUSE'S / PARTNER'S EMPLOYER	OCCUPATION (CURRENT/FORMER)	HOW LONG EMPLOYED?		BUSINESS PHONE NO.
EMPLOYER'S STREET ADDRESS	CITY AND STATE			ZIP CODE
WHO CAN WE CALL IN AN EMERGENCY, OTHER THAN YOUR HOME PHONE:		E-MAIL:		

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE

GOVERNMENT MANDATED QUESTIONS:

RACE ☐ Caucasian ☐ Afro-American ☐ Hispanic ☐ Asian ☐ American Indian ☐ Alaskan Native ☐ Pacific Islander Other _____

PRIMARY LANGUAGE ☐ English ☐ Spanish ☐ Other _____

ETHNICITY (CHECK APPROPRIATE)

☐ NO, Not Hispanic, Latino, or Spanish Origin ☐ YES, Mexican, Mexican-American or Chicano Origin

☐ YES, Puerto Rican Origin ☐ YES, Cuban Origin ☐ YES, another Hispanic, Latino or Spanish Origin

NORTHERN ADDRESS:

Street: _____ City_____ St _____ Zip_____

Phone _____

I certify that all the above information is accurate. I hereby authorize the release of any information necessary to process my claims. I hereby authorize the release of my medical information to my referring health care provider as well as to those I may be referred to for consultation and/or treatment. Payment of any government benefits may be made either to me or to the party who claims assignment.

I authorize the payment of medical benefits directly to my physician. I am financially responsible for any unpaid balance due. I agree to pay any deductibles, co-insurances and co-pays. I understand that I am financially responsible for any charges not covered by my insurance and if I fail to give updated current information and the claim is denied, I will be responsible for the entire balance.

In the event your check is returned for any reason, your account will be charged $35. If we determine your account should be placed with an outside collection agent or an attorney, you will be assessed an additional 30% of the balance due.

Signed _____ Date _____

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Authorization for Release of Information – Compound Release

Name of Patient_____Date of Birth _____

ADVANCED UROLOGY OF SOUTH FLORIDA is authorized to release protected health information about the above-named patient in the following manner and/or to selected persons.

Check each person/entity approved to receive information.	Check type of information that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other_____
☐ Other person (s) (provide name and phone number)	☐ Financial ☐ Medical
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____
☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	

Patient Rights:

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

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Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address: _____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:

  _____
- ❑ Other: _____

  _____

Prepared By _____

Signature _____

Date _____

ADVANCED UROLOGY OF SOUTH FLORIDA

5350 WEST ATLANTIC AVENUE, SUITE 102 • DELRAY BEACH, FLORIDA 33484 • 561-496-4444 • FAX 561-496-2001

PATIENT HISTORY FORM

Todays Date	*Date of Birth*	*Age*	*Primary Doctor*
Last Name	*First Name*	*Middle*	__ male __ female

Chief Complaint

What is the main reason for your visit?	
When did you notice the problem?	*How long does the problem last?*
Where is the problem located?	*What makes it better or worse?*
How severe is the problem on a scale of 1 to 10? mild < 1 2 3 4 5 6 7 8 9 10 > severe	
Does the problem interfere with normal functions?	

PAST MEDICAL HISTORY & SOCIAL HISTORY

Marital Status: __ Married __ Single __ Divorced __ Widowed __ Separated	
Race: __ Caucasian __ African-American __ Hispanic __ Other, please specify:	
Education: __ HS/GED __ College __ Post-Graduate __ Other, please specify:	
Occupation:	__ Part-time __ Full-time __ Retired

Smoking History

Do you now or did you ever smoke? Yes / No		# Packs: _____ per day / week
Date Started:	# Years smoking:	Date Quit:

Alcohol Use

Do you drink alcohol?			
__ Yes	_____ Drinks per __ day __ week __ month __ year	Type of alcohol consumed: __ Beer __ Liquor __ Wine	Drinking Habits: __ Social __ Light __ Moderate __ Excessive

List Any Surgeries/Including Dates:

List Any Medical Illness / Including Dates:

Family History

History of Prostate Cancer? ☐Yes ☐No If yes, Who?_____

Father ☐Alive ☐Deceased at Age _____ Medical Problems?_____

Mother ☐Alive ☐Deceased at Age _____ Medical Problems?_____

Siblings Medical Problems: _____

Children Medical Problems: _____

Remarks:

REVIEW OF SYSTEMS:

General:	Weight Loss Or Gain	Fever	Chills
Skin:	Skin Rash	Persistent Itch	
Nose:	Stuffiness	Sinus Pain	
Respiratory:	Wheezes	Cough (Dry Or Wet, Productive)	
Cardiovascular:	Swelling (Edema)		
Gastrointestinal:	Nausea/Vomiting	Constipation	
UrologicalRenal:	Burning Or Pain	Blood In Urine	Change In Urinary Strength
Musculoskeletal:	Back Pain	Muscle Or Joint Pain	
Neurological:	Dizziness	Fainting	
Hematologic/Lymphatic:	Ease Of Bruising	Ease Of Bleeding	
Endocrine:	Thirst (Polydypsia)	Change In Appetite	
Psychological:	Depression	Nervousness	

ADVANCED UROLOGY
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Master Medication List

Date: _____/ _____/ _____.

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____/ _____/ _____.

Do you have ALLERGIES to any medications and /or foods? ☐ Yes ☐ No

If yes please List: _____

_____

_____

Urologic Diagnosis: _____

_____

Please list all medications you are currently taking:

Medication	Daily Dose & Frequency	Reason

Pharmacy Name: _____ Pharmacy Phone: _____

5350 West Atlantic Ave, Suite 102 *Delray Beach, FL 33484* Ph: (561)496-4444 Fax: (561)496-2001